# THE MISSOURI SENATE INTERIM COMMITTEE ON MEDICAID TRANSFORMATION AND REFORM

# DRAFT REPORT

**December 15, 2013**

**Prepared by**
**Senate Staff**

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December 15, 2013

The Honorable Tom Dempsey, President Pro Tempore
State Capitol, Room 326, Jefferson City, Missouri 65101

Dear Mr. President:

The Senate Interim Committee on Medicaid Transformation and Reform, acting pursuant to Senate Rule 31 of the Missouri Senate, has met, taken testimony, deliberated, and concluded its study on the various issues facing Medicaid in Missouri as it relates to reforming Medicaid by improving system efficiency, financial stability and delivery of care. The committee now presents to the General Assembly a report of information and proposed recommendations of actions to address this issue.

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Senator Gary Romine, Chair

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Senator David Sater, Vice-Chair

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Senator Dan Brown

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Senator Doug Libla

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Senator Rob Schaaf

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Senator Wayne Wallingford

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Senator Jay Wasson

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Senator Joseph Keaveny

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Senator Paul Levota

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Senator Jamilah Nasheed

# I. EXECUTIVE SUMMARY

**Brief Statement about Medicaid in Missouri**

"Nearly all states are implementing delivery and payment system reforms designed to integrate and coordinate care, and to have the reimbursement system encourage and reinforce improvements in quality of care and health care homes" (1 )

Facts about current Medicaid and ACA and Federal Reform from Medicaid 101 presentation (TO BE COMPLETED)



1 "Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014", The Kaiser Commission on Medicaid and the Uninsured, prepared by Vernon K. Smith, Robin Rudowitz and Laura Snyder, October 2013, Page 63

# II. OVERVIEW

At the end of the First Regular Session of the 97th General Assembly, President Pro Tempore Tom Dempsey tasked senators with studying the Medicaid Program in the State of Missouri, issue a report and make recommendations to the General Assembly for legislative action no later than December 15, 2013. To that end, Senator Gary Romine, chair of the committee, asked committee members to develop an innovative health care paradigm that provides high quality, cost effective care to Missourians while keeping those services affordable and accountable to the taxpayers who fund such services.

The membership of the committee consisted of the following Senate members: Senator Gary Romine, Senator David Sater, Senator Dan Brown, Senator Doug Libla, Senator Rob Schaaf, Senator Wayne Wallingford, Senator Jay Wasson, Senator Joseph Keaveny, Senator Paul Levota, and Senator Jamilah Nasheed.

The committee held public hearings and solicited testimony regarding a wide range of issues related to Medicaid in Missouri with an eye toward setting goals and recommendations for the coming legislative session. Hearings were held on the following:

July 8-9, 2013
August 14, 2013
September 11, 2013
October 2, 2013
November 13, 2013

Oral and written testimony was provided on such topics as:

I. Update from the Departments of Social Services, Mental Health and Health and Senior Services on the progress of previous recommendations from the Medicaid Reform Commission in 2005
II. Public Testimony and Access to care
III. Supply-Side of Health Care- exploration of potential reforms and alternative approaches for the financing, payment and delivery of health care
IV. Open discussion from invited presenters
V. Demand-Side of Health Care: Altering Consumer Utilization

# III. SYNTHESIS OF INFORMATION AND TESTIMONY RECEIVED

In the course of the examination and public hearings on the issue of transformation and reform of Missouri's Medicaid program, the committee gathered information from witnesses and reports to assist the committee in making recommendations.

### A. Medicaid 101 and Updates from the Departments on Medicaid Reform Commission 2005 Recommendations, July 8, 2013

The committee was presented with the basics of Medicaid in Missouri which included such topics as:

(1) Services and service delivery systems; (2) Provider reimbursement levels; (3) Financing and budget; (4) Hospital reimbursement; (5) Provider taxes; and (6) ACA and Federal Health Reform and Transformation considerations.

(To see the information in detail please see Appendix A)

The committee then received oral and written testimony from the Departments of Social Services, Mental Health and Health and Senior Services providing an in-depth update on the implementation progress of the recommendations from the 2005 Medicaid Reform Commission. The committee was pleased to learn that of the 80 recommendations from the Commission, progress has been made in more than half, 51, of such recommendations. There was "attempted and some progress" made in 18 of the recommendations and "little or no progress" made in just three of the recommendations. (Although the department reported no progress in establishing a new Disabled Employee's Health Assistance Program, in fact the recommendation was achieved when the general assembly passed the Ticket to Work Health Assurance Program in 2007. The program was extended this year to 2019).

The departments noted that there were six main themes in the 2005 recommendations. Below are some of the examples of progress achieved:

(1) *Modernizing technologies*- progress with electronic health records, telemedicine and CyberAccess;
(2) *Broadening and deepening care coordination strategies*- More than 35,000 medically needy

participants receive comprehensive care management through health homes and the DM 3700 initiative, managed care was expanded;
(3) *Improving program operations*- Managed care contracts have been aggressively managed, use of evidence-based prior authorization enhancement;
(4) *Ensuring program integrity*- The newly organized Missouri Medicaid Audit and Compliance (MMAC) formed to consolidate and coordinate integrity efforts across departments;
(5) *Promoting consumer information and responsibility*-Health home programs for chronically ill, smoking cessation and drug therapies implemented; and
(6) *Expanding provider networks and services*- Community mental health centers and federally qualified health centers were merged in two communities to promote behavioral health/primary care integration, various demonstration projects and partnerships formed in the St. Louis, Kansas City and Columbia areas. (Please see Appendix B for more detailed information)

### B. Public Testimony and Access to Care, July 9, 2013

The committee invited the public to speak and heard from 25 people ranging from Medicaid participants, providers such as physicians and mental health counselors, consumer advocates, and representatives from religious organizations and legal services on the issue of "Access to Care for all Missourians." (See Appendix C for a list of witnesses.)

*Core themes from Public Testimony*

A majority of the witnesses urged the committee to consider Medicaid expansion under the Affordable Care Act, arguing that expansion would provide health coverage for numerous persons with mental illness and substance abuse problems rather than crowding prisons, jails and emergency rooms. Erin Brower from the Partnership for Children argued that expansion would bring about coverage to the approximately 100,000 children who are currently eligible for Medicaid but who are not enrolled. She noted that if parents have coverage then the children will be enrolled as well.

Todd Richardson from the Missouri Association for Community Action commented that if the state increased access to preventive care for all Missourians, the end result would be lower costs across all sectors. Richardson stated that "expanding insurance coverage to more adults would decrease the amount of cost that hospitals must absorb in uncompensated care".

A number of witnesses urged the committee to not only extend Medicaid coverage for those covered under the ACA, such as the working disabled, but to consider first expanding eligibility for the disabled and elderly. The Missouri Developmental Disabilities Council noted how the asset limits in Missouri Medicaid are one of the lowest in the nation. Joannie Gillam, of the Disabled Citizen Alliance for Independence pointed out how Missouri's asset limits are so low, that many of the Medicaid recipients who are disabled are just one home or car emergency repair from complete impoverishment due to the small amount of money such recipients are required to maintain in their bank accounts in order to maintain eligibility.

Lee Parks a physician with Crider Center, stated that savings could be gained in the long run in the Medicaid program by offering dental, physical therapy and increased mental health and screening services. These areas would curb costs in the emergency room in the areas of diabetes, heart disease, and back pain/narcotics abuse. Dr. Parks also argued for higher provider reimbursement. Another witness argued for Chiropractic physician services to be added into the Medicaid health care plan.

Anita Parran of AARP Missouri stated that Medicaid expansion is important for those persons who are over age 50 but not yet eligible for Medicare as this particular demographic has been hit the hardest by the economic downturn having to compete with younger people for jobs. She testified that the "majority of Missouri residents age 45+ believe in the importance of Medicaid and support expansion in their state."

Joel Ferber from Legal Services of Eastern Missouri presented testimony before the committee on issues regarding the need for Medicaid expansion as well as giving examples and offering advice on reform possibilities for Medicaid in Missouri. Mr. Ferber offered many arguments for Medicaid expansion under the ACA, noting that "part of reforming health care is providing health coverage to people before they get sick, and helping them get the preventative care that they need to stay healthy." As to reform, he argued for improved care coordination such as the current MO HealthNet Primary Care Health Home Program, reducing churning through continuous Medicaid eligibility such as the longstanding state option to continuously enroll children in Medicaid for 12 months, coordinated fee-for service programs rather than state wide managed care for all populations. If Missouri were to extend managed care statewide, he proposes maintaining certain carve outs for pharmacy, transplant, community psychiatric rehabilitation and comprehensive drug and alcohol treatment services. He urges caution as to incentives for health behavior and asks for the state to further consider addressing provider participation by increasing reimbursement

rates for providers. In the end, he noted that any reforms must meet existing legal requirements even within the parameters of a waiver from the federal government.

### C. Supply-Side of Health Care- August 14, 2013

Presentations were given on the issues of exploration of potential reforms and alternative approaches for the financing, payment and delivery of health care.

*Core themes from provider testimony*

A common theme that emerged centered on changing the incentives for providers from a Fee-for Service model to another payment model such as a capitation or risk capitation model. Team or integrated care, population health management, medical management, and medical homes were all topics that were mentioned. Many of the witnesses provided information regarding how many of these delivery models are already in place or being put in place. There was also a common theme about the usefulness of health information technology and telehealth when incorporating the new delivery models. There was also testimony regarding the need to manage the super utilizers as well as those who abuse the process by inappropriate use of the emergency room.

Tom Hale testified at the hearing that Mercy Health is moving toward a new model of care delivery that focuses on population management, coordinated care and a wellness/prevention model. This model is premised on the belief that care should be served in the local community as the very concept of a "health care home" should be where the patient resides and has social and family support. Mercy is therefore looking for tools that will serve the participant in the community. Such tools include telehealth and recognizing the unique needs of the Medicaid population to be served. Such considerations that are necessary include: identification, access to care, coordination of care and cultural disparity. Dr. Hale suggested that the committee look into changing the payment methodology for primary care and structuring payments around population management; establish a regulatory environment that will support the primary care shortage by including other providers and simplifying the licensing process for telehealth physicians.

Cerner, a health care information technology corporation, recommended a "move toward a system of care focused on the health status of a population, with an aligned

payment model." The state should support quality improvement efforts similar to the shared savings program in Medicare, medical homes and accountable care organizations (ACOs). These models can incorporate personal health records to manage chronic conditions, measure compliance and wellness achievements and offer a means to allow recipients to communicate with providers and complete e-visits. The Medicaid program could pursue financial and quality transparency regarding providers and services so that consumers can make the best choices regarding health care.

Christian Jensrud of Wellpoint, a health benefit and managed care company, talked about the need for getting a handle on the dual eligible population by encouraging collaboration between coordinated long-term care programs and Medicaid managed care organizations. He argued that such collaborations can result in both health improvement and significant savings. Wellpoint has seen improvements in quality care by implementing provider quality incentive programs, holistic disease management practices and telehealth for specialty care in rural and underserved areas.

Dr. Charles Willey of Innovare Health Advocates argued against Medicaid expansion, stating that doing so would "perpetuate a vicious cycle of more government funding, bringing more destructive regulation, necessitating greater bureaucracy, causing higher costs that directly decreases access which worsens health . . ." He stated that since 1992, his business model has been prepaid for population health management, one person at a time. He has observed that good patient health lowers health care costs, which in turn opens access to quality care, which in turn increases patient health, thereby creating a cycle of health. His recommendations for reform include: provider and beneficiary accountability as well as an accountable benefit design.

Dr. Jeffery Kerr testified about the problems he has seen as a Medicaid provider for the past 27 years. He noted the need for dental health coverage as the emergency room is filled with patients with dental pain and abscesses. He has observed unnecessary laboratory re-testing and believes it could be managed better through technology. He recommended that more providers would participate in the much needed chronic care management if such providers were better reimbursed to do so.

Dr. Katie Lichtenburg from the Missouri Academy of Family Physicians talked about the need for coordinated care and specifically mentioned patient-centered medical homes. She suggested identifying the top spenders in the Medicaid program and assigning them a personal care coordinator to work directly with a physician and

create a "Hot Spotter" list. She also commented on the problem with access to see the family physicians, particularly for those who have to schedule five days in advance for Medicaid transportation. It is in situations such as these that the patient then goes to the emergency room for "after-hours" or more immediate care.

Dr Robert Atkins from Aetna, a managed health care company, recommended that Missouri implement fully integrated managed care for all populations; partner with providers to create integrated systems of care, and focus the use of resources where they are most likely to make a difference. There was also testimony from the Community Mental Health Centers regarding the Health Homes and Primary Care Health Home initiatives underway in Missouri and how such programs provide a health home for individuals with serious mental illness and another chronic condition.

### D. Open Discussion from Invited Presenters- September 11, 2013

Invited presenters discussed such topics as over-utilization and under-utilization, cost sharing provisions, premium assistance as a Medicaid expansion option and medical homes or coordinated care, wellness incentives, Section 1115 Medicaid Waivers and the need for Medicaid expansion.

Dennis Smith from McKenna, Long and Aldridge argued that the problem with Medicaid is not the cost of health care but rather, it is excess cost driven by both over-utilization and under-utilization in the wrong areas. He states that efficiencies could be found in five main functions of Medicaid: eligibility, benefits, payment, service delivery and administration. He offered advice on how to manage the dual eligible population, noting that to be successful, "dual demonstrations must save money for the state, save money for the federal government (in Medicare as well as in Medicaid), be better for the individual, and must be a viable business model to attract sufficient community partners."

Sydney Watson, a Saint Louis University Law School professor offered advice in the areas of Medicaid expansion, premium assistance programs being advanced in other states and wellness incentives. She presented testimony regarding the health benefits of extending health coverage to a previously uninsured population. She described the differences between implementing a premium assistance program for the expansion population through either a state option or through a Medicaid waiver. Finally, Professor Watson explained some of the growing body of literature suggesting that "financial incentives can be effective at achieving behavior change that requires a

single activity like getting a flu vaccination or checkup" rather than for ongoing behaviors such as smoking cessation. She noted that there isn't evidence to show rewards or penalties lead to meaningful changes in health behaviors and outcomes.

Christie Herrera from the Foundation for Government Accountability made the case for patient-centered Medicaid reform. She noted how "Old Medicaid" focused on the government as consumer with complex programs, government controls, centralized planning/purchasing, and a blank check which led to unsustainable growth. Whereas, the "New Medicaid" focused on patients as consumers, consistent policies, more consumer choice, marketplace decision-making and defined investments which in turn leads to predictable growth. She then explained the reform efforts in Florida, Louisiana, Kansas and North Carolina. These efforts have been successful because all benefits and populations were carved into the reform efforts, there was smarter plan structure and funding, there were different plans to offer more competition, there were customized benefits, specialty plans and health incentives and participants were provided with independent choice counseling.

### E. Demand-Side of Health Care- Altering Consumer Utilization, October 2, 2013

Invited presenters discussed such topics as the efficacy of preventive medicine, disease management, and electronic medical records. Such witnesses generally recommended medical homes, performance metrics and commercial rates.

Ed Weisbart from the Consumers Council of Missouri argued that the commonly praised strategies of preventive care, electronic records and pay for provider performance do not reduce cost. Instead, Mr. Weisbart recommends the state create financial incentives for providers to work in underserved areas by reimbursing physicians at 120 percent of Medicare rates.

The St. Louis business Coalition supported expansion. The coalition argued that there is a huge opportunity to align across state sectors and to align the message across payers. There can be quality improvement such as the case with infection control in hospitals.

Lauren Tanner, from Ranken Jordan Pediatric Specialty Hospital, recommended implementation of an efficient care coordinated model. Craig Henning, from the Centers for Independent Living, noted the problems with geographic access to care.

He urged the state to consider health care homes and pilot projects for managed care but he has found mixed effectiveness with Accountable Care Organizations.

Timothy McBride from the MO HealthNet Oversight Committee and a health economist with Washington University, discussed insurance benefit designs, improving population health and transformation. He believes that to improve the system, it is necessary to have health homes and programs like Money Follows the Person as well as improvements to health information technology.

Jeanette Mott Oxford, with the Missouri Association for Social Welfare, brought in 1,700 witness forms all urging Medicaid Expansion. She argued that expansion will keep hospitals open. She also noted that when looking at the population in Medicaid and designing incentives or penalties for participants, it is important to note that it is not just a culture of missing appointments but it is about the population living in the "chaos of poverty" that creates misuse of services.

Sergeant Mike Krohn from the Boone County Sheriff's Department explained to the committee how the sheriffs and law enforcement officers are used as mental health professionals. They are forced to triage emergency situations. He stated that 25 to 30% of inmates in the Boone County jail are receiving mental health services. When asked how this problem could be fixed, he stated that they simply needed more money for mental health beds and for training.

The committee also heard from senate staff regarding a cost avoidance analysis of having Medicaid managed care statewide versus fee-for service model, payment reductions to hospitals across the state as a result of federal sequestration and Medicare cuts, and the new federal rules regarding permissible requirements with respect to cost sharing from Medicaid participants. States will also be allowed to charge $8 copays for non-emergency use of the emergency department for those with incomes equal to or less than 150% of the federal poverty level. These participants are currently exempt from such cost sharing. For participants with incomes higher that 150%, there is no limit on the maximum cost sharing for non-emergency use of the emergency department.

## IV. RECOMMENDATIONS

After review of all information received during the hearings regarding areas of improvement for the current Medicaid program, the committee believes that before the state can consider expanding eligibility and increasing the number of participants to the program, transformation of the entire Medicaid program must occur. As noted recently by the Kaiser Commission on Medicaid and the Uninsured, "[n]early all states are developing and implementing payment and delivery system reforms designed to improve quality, manage costs and better balance the delivery of long-term services and supports across institutional and community-based settings."(2)

Using the goals of attaining quality, managing costs and improving delivery of care for all participants including the super utilizers, the committee puts forth the following recommendations:

1. **The current MO HealthNet Managed Care program should be extended statewide for all populations currently in managed care, which would primarily include low-income custodial parents, pregnant women, and children. Every Medicaid participant in managed care shall designate a primary care provider.**

The committee believes it necessary to have as many Medicaid participants in a coordinated or managed care delivery system such that the participants can benefit from improved quality outcomes and the state can be better stewards of taxpayer funds. By extending managed care statewide with current population groups it is believed that the state can achieve such goals. There was testimony presented that when comparing similar population groups, the cost avoidance as a result of managed care was approximately 3% savings or $38 million annually ($14 to $15 million in the state share).(3) The MO HealthNet Division has reported quality improvements since 2005 with respect to managed care participants such as 29% increase in timely prenatal care, 15% increase in postpartum care, 11% increase in annual dental visits, and 9% increase in adolescent well-child visits. (4)

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2 "Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014", The Kaiser Commission on Medicaid and the Uninsured, prepared by Vernon K. Smith, Robin Rudowitz and Laura Snyder, October 2013, Page 5

3 "Medicaid Managed Care versus Fee-For-Service Cost Avoidance Analysis", Testimony before The Missouri Senate Interim Committee on Medicaid Transformation and Reform , Adam Koenigsfeld-Senate Staff, p. 3, October 2013 and "Missouri Medicaid and Reform" Home State Health Plan, Shannon Begley, August 14, 2013, p. 2

4 "Missouri Medicaid and Reform" Id. at p. 2

When awarding contracts for such managed care populations the state must require that the MCOs guarantee, at a minimum, the following:

> Improve health outcomes with comprehensive care coordination
> Increase usage of preventive services and reduce unnecessary ER visits
> Promote personal responsibility of enrollees
> Improve state budget predictability and taxpayer savings
> Increase efficiencies and transparency
> Reduce fraud, waste and abuse of the system. (5).

2 **All other populations excluding participants in skilled nursing facilities that are currently in the fee-for-service program should be transitioned to regionally-based Accountable Care Organizations serving as "single points of accountability" for quality, cost, and access to coordinated care. The new delivery model will encompass all aspects of care except pharmacy services including physical and behavioral health. All members must be linked with a primary care provider of their choice in an ACO.**

Although in the Kaiser survey of fifty states managed care continues to be the main avenue for implementing reforms, "significant reforms are also occurring through health homes, patient-centered medical homes, ACO's, and other initiatives that coordinate acute and primary care with behavioral health care and with long-term care."(6) The committee believes that many of the recommendations listed below and other suggestions made throughout the committee process will bear fruit under both a managed care and Regional Accountable Care Organization structure.

Although generally an ACO consists of a group of health care providers that agree to share responsibility for the delivery of care and the health outcomes of a defined group and the cost of care, many states have adapted the ACO concept to be broken out across a state regionally. Such states include Oregon, Colorado, and Alabama.

As was noted by the Center for Health Care Strategies:

"[s]tates can use their regulatory powers, managed care contracting, and direct

5 "Missouri Medicaid Reform", Id at p 3
6 "Medicaid in a Historic Time of Transformation", Id. at p. 63.

> ACO contracting to craft programs with maximum flexibility and incentives for innovation. The market-leader role may be a big shift for some states. Given the relative nascence of the ACO model, Medicaid may want to engage a range of community stakeholders to design an approach that functions well to meet a variety of needs. Medicaid can assist in the development of robust ACO models by leading efforts to integrate financing for physical health, mental health, behavioral health, and long-term supports and services, and by fostering collaborations with state and local agencies responsible for funding critical social services. At the implementation level, Medicaid can facilitate alignment across MCOs, ease administrative burdens for ACOs, and either lead key technical support activities, such as data aggregation and data feeds, or leverage their MCO contracts for these supports." (7)

Regional Accountable Care Organizations (ACOs) in Missouri will evolve out of the state's existing managed care organization (MCO) infrastructure, replacing fee-for service. However, if such a model were to be pursued in Missouri, a state statute, Section 208.950.4, RSMo, will have to be modified to allow the elderly, blind and disabled to be enrolled in any coordinated care model.

The Regional ACOs can be corporate entities or contractually-linked provider networks formed through the collaboration of MCOs, hospital systems, community-based organizations, and other entities. Depending on the given area, Regional ACOs will initially be either existing MCOs or newly merged MCOs with local community based mental health centers and county government agencies. (8)

This new model for Missouri would also grow and expand the current Department of Mental Health DM 3700 and Health Home programs to coordinate care, particularly as the elderly, blind and disabled have not previously been served under coordinated care in Missouri.

It is crucial that Regional ACOs have a strong community focus, with community health care stakeholders and community organizations represented within a Regional ACO governance structure. Other states have required that Regional or community-based ACOs form a Community Advisory Council, including community and

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7 "Accountable Care Organizations in Medicaid: Emerging Practices to Guide Program Design", Center for Health Care Strategies, Inc, by Tricia McGinnis and David Marc Small, February 2012, a p.

8 "Accountable Care Organizations in Medicaid, Id. at p.

government representatives to meet regularly to ensure that local health care needs are being met.

The Regional ACOs will be full-risk-bearing entities reimbursed through a global payment methodology developed by the State.

The committee heard from numerous witnesses who argued that if some form of coordinated care is advanced in Missouri for state-wide and all populations, it is crucial that there be vigorous management and oversight by the MO HealthNet Division in order to ensure accountability and quality measures are met. Therefore, when developing the ACOs, at a minimum, the following goals should be kept in mind:

- Develop statewide uniform data and analytics integration.
- Require the contracts to adopt mandatory medical loss ratios.
- The reforms should include risk-sharing arrangements between ACOs and payers.
- Sponsor a variety of community collaboration initiatives to promote cost-saving and health improvement activities at the local level.
- Use the lessons and infrastructure from the DMH 3700 project and DSS medical home initiative to determine standards for funding under an ACO initiative.
- Ensure that there is an adequate provider network through the ACO agreements.

**3. Manage super utilizers beyond current care management programs by building on the DMH 3700 and health homes.**

The committee heard from numerous witnesses about the success of the innovative models initiated in Missouri with respect to behavioral care, health homes and primary case management. It has also been made clear by witnesses that it is the super utilizers who have not really been managed well in the past and coincidentally are the group of participants who are also the costliest. Now is the time to develop models that will facilitate the coordination and integration of care across the continuum of services, particularly as these groups transition in and out of various long-term care support services and home-and community based services. States have "expressed growing awareness that lack of communication and information-sharing between providers hinders good quality care and increases the risk of duplication, unnecessary

care, and higher costs." (9). These issues could be improved under a Regional ACO model.

4. **DSS shall explore and develop options for transitioning dual eligible individuals to integrate Medicaid and Medicare services. Such change requires the development of a shared savings model with Medicare for dual eligible participants.**

Dual eligibles are those persons who meet eligibility requirements for both Medicare and Medicaid and have been enrolled in both programs. The duals tend to be the poorest and ones with multiple chronic conditions or severe mental disorders. This is why the Affordable Care Act created an office, the Federal Coordinated Health Care Office within the Centers for Medicare and Medicaid Services, to coordinate such care for the dual eligibles. There are 26 states advancing demonstration projects for coordinating care for the dual eligibles. Some policy makers have proposed enrolling duals in state-designed care coordination entities or (CCEs). Under one example of a shared savings plan, there are three entities, the federal government, the state government and a CCE who share any savings from coordinating the care for the duals. Some plans also include the dual eligible in the savings as well. For example, a share of the expected savings is set aside into an account for each dually eligible person enrolled in a CCE. The money in the account is then directed by the patient and can be used to buy additional services and supports including personal assistance services, transportation etc. (10) This is just one example of how one particular Regional ACO could explore the great task of managing the dual eligible population.

5. **Continue to promote the use of technology to enhance both telehealth and transparency in Medicaid.**

Telehealth should be an important part of any Medicaid program. Numerous witnesses testified before the committee on opportunities that could be used by telehealth to help alleviate the problem of both primary care and specialty care provider shortage. Telehealth will allow for the smaller communities to keep the care and patients within their communities. This will stabilize the small hospitals and at the same time keep the patient within the social/family support system of their neighborhood. The technology is already available it just needs to be enhanced and

9 "Medicaid in Historic Time of Transformation", Id. at page 37.

10 "Using Shared Savings to Foster Coordinated Care for Dual Eligibles", The New England Journal of Medicine, Richard G. Frank, January 31, 2013.

the parameters around the use of telehealth streamlined.

Transparency is essential to the program as well. It promotes transforming the Medicaid participant into a smart consumer of services as well as providing integrity to the program. The state should insist on transparency of pricing and quality data in hospitals. These tools would give consumers the necessary information to make informed decision on how and where they choose to seek services. Also, the state should allow for legislative audits of public spending in order to monitor the flow of taxpayer dollars to facilities. All of this would increase public access to financing in order to ensure dollars are spent properly.

6. **Evaluate and analyze ways to decrease emergency room over utilization.**

Countless witnesses, from emergency room physicians to academics testified about the need to curb the tide of emergency room over utilization. This problem is not new. The committee heard about huge strides made in this area through current coordinated care programs and emergency room diversion demonstration projects.

Missouri was the first state to have approved state plan amendments for both a behavioral health and primary care health home programs. According to the Department of Mental Health, preliminary data supports the hypothesis that through the enhanced care coordination and care management there will be a reduction in avoidable emergency room visits. (11)

In 2008, the MO HealthNet Division entered into an agreement with the St. Louis integrated Health Network for a CMS Medicaid Emergency Room Diversion Grant. The purpose of the grant was to establish non-emergency room services. The program incorporated Community Referral Coordinators in emergency departments throughout St. Louis to connect patients in need of non-emergent and follow-up care to an area health center. The program then seeks to find a primary care provider and establish a medical home. Eight CRCs work in seven hospitals to coordinate care.

The committee recommends that such programs be integrated statewide taking into account variations that may be required for different areas and populations.

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11 "2005 Medicaid Reform Commission Recommendations: A Progress Report", Presentation to The Missouri Senate Interim Committee on Medicaid Transformation and Reform, Departments of Social Services, Health and Senior Services, Mental Health, July 2013, page 4 of Top Medicaid Executables

Apparently what was essential to the success of the program was having such CRCs available 24 hours a day. The point of contact had to be made while the patient was in the emergency room.

A similar success story with the ReDiscover program can be found in the Kansas City region. In 2010, through a grant from the Health Care Foundation of Greater Kansas City, safety net providers agreed to divert persons with psychiatric and addiction disorders from hospitals to alternative services. The collaboration consisted of area Community Mental Health Centers, area hospitals, ancillary providers, policy makers, Department of Mental Health and several county funders as well. From 2010 to 2011 over 350 high utilizers were referred and successfully connected with treatment. There were much less emergency room visits once the patient was referred to community care. Only 23% of the patients returned to the hospital. Estimated cost savings during the grant period was $13,700,000 for 19 months of service.(12) The program was such a success that it is in the process of further expansion.

### 7. Continue to enforce participant narcotics abuse and enact a Prescription Drug Monitoring Program

The committee was charged with developing methods to prevent fraud and abuse in the MO HealthNet system. There was testimony regarding participants hopping from emergency room to emergency room and obtaining narcotics. It is imperative that Missouri finally enact a Prescription Drug Monitoring Program as a means of curbing the abuse. Not only is such use costly to the state, but a CMS report noted that increased abuse of controlled prescription drugs " has led to elevated numbers of deaths related to prescription opiods, which increased 98 percent from 2002 to 2006." (13)

### 8. Strengthen Missouri's MO HealthNet False Claims Act and participant abuse investigations.

The committee understands that what can really curb participant fraud is to ensure that there are accurate eligibility determinations. To that end, the Family Support

12 " A Community-Based Approach Using Intensive Outreach and Engagement to Reduce Hospital Costs Associated with High Utilizers", presented by Lauren Moyer, Special Projects Manager

13 "Drug Diversion in the Medicaid Program-State Strategies for Reducing Prescription Drug Diversion in Medicaid", Centers for Medicare and Medicaid, January 2012, at p. 1

Division is forging ahead with implementation of the new MAGI determination provisions found in the ACA.

Not only is there fraud and abuse by participants, but a great deal can be found on the provider side as well. The committee heard testimony from the Missouri Attorney General's office regarding efforts and the amount of fraud taking place. One method that has been adopted by numerous other states and has been attempted by Missouri in the past is to enact a State False Claims Act such that it would entitle the state to 10% increase in the share of Medicaid money retained in a successful legal action. There was a bill filed in the 2010 session, SB 639, that last attempted to strengthen Missouri's current MO HealthNet False Claims act.

9. **Maximize and implement allowable cost-sharing, premiums and deductibles for non-preventive services.**

Keeping in mind the barriers that can be faced by cost sharing requirements on the lowest income participants, the committee believes that the state should take advantage of higher rates of cost sharing that has been approved by CMS recently and how requiring cost sharing could bring about change by the participants. Examples that were given to the committee include cost sharing for inappropriate use of the emergency room.

Under the new CMS rules, states will be allowed to charge $8 copays for non-emergency use of the emergency department for those with incomes equal to or less than 150% of the federal poverty level. These participants are currently exempt from such cost sharing. For participants with incomes higher that 150%, there is no limit on the maximum cost sharing for non-emergency use of the emergency department.

10. **Adopt Incentives for Participants to seek preventive services, encourage healthy behavior and to participate in his or her health care.**

The committee believes that crucial to any reform of the Medicaid system is the need to engage the participant in his or her health care. Not only will this goal work toward better health outcomes but it will also curb the rising cost of care.

The committee heard from witnesses that incentives must be well designed and flexible. Flexibility is needed to accommodate for changes as programs develop and lessons are learned. Not only must the incentives be well designed but must be accompanied by a comprehensive education/outreach to the targeted population. The rewards must be simple and clearly linked to the specific behavioral problem to be addressed.

Other witnesses stressed that a Medicaid transformation embracing care coordination through the use of health navigators, peer counselors, home visiting and other patient supports will help ensure success in any incentive initiatives.

The Center for Health Care Strategies has detailed four main areas for states to explore when there is any discussion of implementing an incentive program:

> -States need to pay attention to the literacy level of the consumers involved and should incorporate comprehensive education as the incentive program is rolled out. The information can be extended by the new coordinated care models expanded statewide.
> - Ensure that community partners are involved with the dissemination of the information.
> - Design elements of the program that recognize the barriers Medicaid consumers face such as transportation and access.
> -Study the consumer participation rates and what incentives are bringing about changes in lifestyle behavior. (14)

### 11. Encourage health savings accounts that can be used for deductibles and copays

The committee received information regarding models of care that incorporate health savings accounts. Some examples can be found in Florida, Idaho and Indiana.

In 2010, Indiana passed legislation which added a requirement for enrollees to make a minimum contribution to their POWER account of $160 annually (but no more than 5% of their income) and allowed both non-profits and managed care entities to pay a

14 Accountable Care Organizations in Medicaid at p.

portion of members' required POWER account contribution to incentivize positive health habits.

Evaluations of the program are promising. Missouri needs to focus on how such a program would work taking into account financing, utilization patterns and healthier patient outcomes.

**12. Increase the asset limit to allow for health care items or services.**

The state of Missouri has one of the lowest asset limits for the Medicaid elderly and disabled individuals in the country. The current asset limit is $999 for a single person and $2,000 for a couple. A recommendation of the committee could be to include an asset limit to $2,000 for a single person and $3,000 for a couple, however the increase in the asset limit would require the individual or couple to use those funds for the sole purpose of purchasing health care related items or to aid in the cost of their health care and related expenses. The funds allowed under the current asset limits could be used by the individual for any item or purchase. Such action of creating these additional funds through the increase of the asset limit would empower the individual or couple to exert more control over their health care decisions and increase the financial stability for these individuals.

**13. Add preventive dental services or adults and disabled to reduce ER visits.**

As discussed in recommendation # 6, a great deal of emergency room visits are preventable and many times could be avoided by less costly preventive care. There were numerous witnesses testifying about the need to provide dental services not only to encourage a better quality of life, but as a means of curbing health care costs.

The committee believes that preventive dental care for adults and the disabled would achieve the goals of both improving quality of care and in in cost savings. Of the top ten cause of Medicaid emergency department visits, dental problems is one that could be reduced by offering preventive care. (15)

**14. Reinvest future transformation savings into technology and provider payments.**

15 "Data Book: Missouri Health and Health Care", Missouri Hospital Association, July 2013, at p 58

The committee also heard from a number of witnesses concerned about the low number of providers, more specifically physicians and dentists, willing to except Medicaid participants. It was also noted that there will be fewer health care providers in general as a result of retirement and due to the fact of a smaller number of individuals pursuing this career. It is the recommendation of the committee to use savings generated from the transformation of the current Medicaid program to increase provider rates to encourage more providers to accept Medicaid participants. The state should provide additional funding for the Primary Care Resource Initiative for Missouri (PRIMO) loan program to increase the number of primary medical, dental, and behavioral health care professionals willing to work in a rural or underserved area of the state.

### 15. Ensure hospital health and sustain the Federal Reimbursement Allowance program.

"Hospital health", especially the health of small, rural hospitals is essential for quality health care and can be a life-and-death matter in emergency situations. Rural hospitals are often the biggest employers in the community. It is essential that steps be taken so that small rural hospitals can remain profitable, up-to-date, and in business. The closure of hospitals in rural communities can result in certain services being so far away that people may not be able to get treatment. (16)

Hospital revenue streams are substantially changing as a result of federally mandated reductions. The Missouri Hospital Association (MHA) estimates payment reductions in excess of $4 billion from 2013-2019. The Patient Protection and Affordable Care Act of 2010 (ACA) mandates aggregate DSH reductions to state DSH allotments beginning in FY 2014. In addition to the Medicaid reductions imposed by the ACA, hospitals are having payments reduced as a result of Medicare rate cuts, sequestration and other federal government restrictive actions ($3.3 billion of the $4 billion).

Medicaid disproportionate share hospital (DSH) payments are paid to hospitals to help offset costs of uncompensated care for Medicaid and uninsured patients. DSH will be reduced 5% for the first three years; 15% for the next year; and 50% thereafter. Beginning October 1, 2013, Missouri's state-specific DSH allotment was reduced by $25.9 million (5.14%). DSH payments are subject to hospital specific

16 Testimony to The Missouri Senate Interim Committee on Medicaid Transformation and Reform, Barbara Davis of the League of Women Voters, July 9, 2013.

limits and state-wide DSH allotments. Annual DSH payments in Missouri are in excess of $700 million.

MO HealthNet currently pays hospitals based on a complicated out-dated reimbursement methodology that isn't used by other third party payers. Hospitals are paid a daily rate (per diem) for each day a patient is in the hospital. The daily rate is based on 1995 costs inflated to 2001. Supplemental payments are then added to align payments with current costs. Even though inpatient stays are subject to precertification by MO HealthNet, the current methodology provides little incentive to manage ancillary tests and services for a patient while in the hospital or manage a patient's condition following discharge.

The Committee believes that payment reforms must be explored to promote consistency among payers, quality and value in hospital inpatient and outpatient settings. Most commercial payers pay based on episodes of care specific to a diagnosis or condition. The committee recommends exploring new methodologies and/or managed care contract requirements that sustain and support rural hospitals while promoting access to care.

**16. Consolidate departments responsible for providing Medicaid services into one agency responsible for the administration and transformation of the Medicaid program. Efficiencies gained should be reinvested into transformation efforts.**

State agencies with Medicaid administration responsibilities include the Departments of Social Services (DSS), Health and Senior Services (DHSS), Mental Health (DMH), and Education. Federal law requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. DSS is the designated single state agency in Missouri and has ultimate responsibility for the Medicaid program, but lacks authority over several components of the program including long-term care services administered by DHSS and mental health services administered by DMH. Even though senior leadership from each department work collaboratively on Medicaid initiatives, it is difficult to manage the program and carry out initiatives at the staff level when multiple department leaders and division heads are involved in the program's administration.

MO HealthNet operates in silos where a decision in one silo can have catastrophic actions that increase costs in another silo. (17) Effective management of the Medicaid program requires the balancing of program and financial priorities for a diverse and vulnerable set of populations. Missouri's decentralized Medicaid program leads to knowledge gaps and lacks a structure where there is a clear line of accountability. (18) A centralized Medicaid program integrates staff expertise and enables existing resources to be efficiently used across departmental silos.

Medicaid appropriations for FY 2014 are close to $9 billion, the largest program in state government. Medicaid is the second largest user of state General Revenue. Implementing transformation recommendations will require refocusing efforts of existing staff to lead federal waiver and demonstration submissions, analyze care data, and strengthen contracts. Efficiently transforming Missouri Medicaid without jeopardizing our current financing structure (provider taxes) will take the efforts of all staff under central cabinet-level leadership.

The committee also believes that if we are to reform all aspects of the Medicaid program, it would also be wise to repeal the MO HealthNet Oversight Committee and revise the current Joint Committee on MO HealthNet to become the Joint Committee on Medicaid and Medicaid Transformation. The Joint Committee on MO HealthNet has never been fully appointed or met. Now that the state is embarking on Medicaid Transformation, it would be wise to have a joint committee overseeing such changes truly monitor, vote and take action through the legislative process. Because of the enormous impact Medicaid has on program participants and the state budget, it would also be helpful for legislative members to take a proactive role in ongoing policy development, long range planning and program oversight. A joint committee provides an opportunity for legislators interested in health care to become subject matter experts.



17 Testimony to The Missouri Senate Interim Committee on Medicaid Transformation and Reform, Jeffery Kerr, D.O, August 14, 2013

18 "MO HealthNet Comprehensive Review Final Report, Final Version", The Lewin Group, April 30, 2010.

**Appendix A- MEDICAID 101 Powerpoint Presentation**

**Appendix B- Medicaid Reform Commission 2005 Progress Report from the Departments of Social Services, Mental Health and Health and Senior Services**

**Appendix C- List of Witnesses Who Testified at Hearings**

# Appendix C- Witnesses Who Testified at Hearings

**July 8, 2013- Medicaid 101 and the Medicaid Reform Commission 2005 Update**

1. Senate Staff- Adam Koenigsfeld, Adriane Crouse and Marga Hoelscher
2. Missouri Departments of Social Services, Mental Health and Health and Senior Services

**July 9, 2013- Public Testimony and Access to care**

1. John Orear- National Alliance on Mental Illness (NAMI) and parent
2. Erin Bower- Partnership for Children
3. Sarah Gentry- National Multiple Sclerosis Society
4. Todd Richardson- Missouri Association for Community Action
5. Joanie Gilliam- Disabled Citizens Alliance for Independence
6. Chuck Hollister- Missouri Psychological Association
7. Dr. Mark Bradford- Ozark Psychological Association
8. Andrea Routh- Missouri Health Advocacy Alliance
9. Joel Ferber, Legal Services of Eastern Missouri
10. Sherri Keller- Self
11. Mike Keller- Missouri Council for the Blind
12. Richard MCCullough- Missouri State Chiropractors Association
13. Brent Gilstrap- Missouri Mental Health Counselors Association
14. Barbara Davis- League of Women Voters
15. Sayra Gordillo- Self/Student
16. Dawn Martin- self
17. Joe Hardy- Missouri Rural Crisis Center
18. James King-Adapt of Missouri
19. Wyndi Chambers- Self/ Foster and Adoptive parent
20. April Neiswender –Self
21. Deborah Minton- Self
22. Wayne Lee-Advocate for disabled
23. Jackie Lukitsch- NAMI/ National Alliance on Mental Illness of St. Louis
24. Michelle Scott-Huffman- Missouri Faith Voices
25. Anita Parron- AARP

**August 14, 2013 Supply-Side of Health Care- exploration of potential reforms and alternative approaches for the financing, payment and delivery of health care**

1. Dr. Tom Hale, Executive Director- Mercy Telehealth Services
2. Carrie Sherer, Director of Government Affairs- Cerner
3. Dr. Heidi Miller, Internal Medicine- Primary Care Association
4. David Smith, -Blue Cross Blue Shield
5. Christian Jensrud, Vice President for Business Development- Wellpoint
6. Daniel Landon, Senior Vice President of Governmental Affairs- Missouri Hospital Association
7. Dr. Charles Willey, Internal Medicine- Missouri State Medical Association- Innovative Health Advocates
8. Dr. Jeffrey Kerr- Missouri Association of Osteopathic Physicians and Surgeons
9. Steve Halper- Healthcare Fraud Control Unit
10. Joan Gummels- Missouri Attorney General's Office
11. John Kopp- Missouri Attorney General's Office- Medicaid Fraud Control Unit
12. Pam Victor- HealthCare USA/Aetna
13. Dr. Bob Adkins- HealthCare USA/ Aetna
14. Dr. Larry Lewis- Missouri College of Emergency Physicians
15. John Marshall, Communications Officer- Signature Medical Group
16. Dr. Katie Lichtenburg- Missouri Academy of Family Physicians
17. Jason White, Missouri Ambulance Association
18. Steve Goldberg-WellCare Health Plans, Inc
19. Alaina Macia- Medical Transport Management
20. Shannon Begley- Home State Health Plan
21. Bob Reid- Page Minder
22. Kim Yeagle- Burrell Behavioral Health
23. Christy Henley- Clark Community Mental Health Center
24. Brent McGinty- Missouri Coalition of Community Mental Health Centers
25. Mary Schantz- Missouri Alliance for Home Care

**September 11, 2013 Open discussion from invited presenters**

1. Sidney Watson, Professor- St. Louis University School of Law
2. Christie Herrera- Foundation for Government Accountability
3. Dennis Smith- Mckenna, Long and Aldridge LLP
4. Margarida Jorge- Healthcare for America Now

**October 2, 2013 Demand-Side of Health Care: Altering Consumer Utilization**

1. Dr. Ed Weisbart, Vice President- Missouri Consumer Council
2. Louise Probst, Executive Director- St. Louis Area Business Health Coalition
3. Lauren Tanner, President and CEO- Ranken Jordan Pediatric Specialty Hospital
4. Dr. Timothy McBride, Professor, Washington University's Brown School of Social Work
5. Sergeant Mike Krohn- Boone County Sheriff's Department
6. Jeannette Mott Oxford, Executive Director- Missouri Association for Social Welfare
7. Craig Henning, Executive Director- Disability Resource Association
8. Senate Staff- Adam Koenigsfeld, Adriane Crouse and Marga Hoerchler